INDIAN HEALTH SERVICE

Documenting Patient Education
Volume I
(PEPC)

14th Edition
January 2008

FOREWORD

The PEP-C (Patient Education Protocols and Codes committee) has diligently worked to add all protocols that were requested by providers or departments. We hope that you find the codes helpful in documenting your patient education. Some of the codes found in this book will be used in the Clinical Reporting System (CRS) and GPRA as indicators of performance and in the attainment of GPRA and CRS Indicators.

As co-chairs of this committee we would like to sincerely thank all the members and guests of this committee. As usual they spent long hours preparing for the committee meeting and even longer hours in committee. They all deserve our appreciation. Without these dedicated committee members this would not be possible. We would also like to thank Mary Wachacha, IHS Chief of Health Education. Without her vision none of this would be possible. Many years ago, nurses in the Tucson Area, led by Elizabeth Dickey, R.N. developed the first brief manual envisioning an easier way to document education in the Indian Health Service. A special thanks to Shirley Teter, OIT, for her assistance in formatting and ensuring consistency in our document. We would like to thank all the I/T/U programs for their dedication to the documentation of patient and family education. Finally, we are indebted to our colleagues in the Indian Health Service for their support, encouragement, and input.

If you have new topics or codes you would like to see in future editions of the Patient Education Protocols and Codes please let us know. Submissions are requested and encouraged! Please e-mail submissions in Word format. Please try to follow the existing format as much as possible using mnemonics (codes) that are already in existence. The submissions will be reviewed by the committee and may be changed extensively prior to their publication for general use. New submissions should be sent to:

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FOREWARD TO THE 14th EDITION OF THE PATIENT EDUCATION PROTOCOLS

The current membership of the National IHS Patient Education Protocols Committee:

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TABLE OF CONTENTS

About This Document

This document is Volume I for the Patient Education manual. Documenting Patient Education contains the information you need to know when you document Patient Education about a patient.

Because the previous Patient Education manual became so large, we decided to divide the manual into two volumes:

Volume 1 is Documenting Patient Education. You can print this volume as part of your Patient Education manual.

Volume 2 is Patient Education Protocols and Codes. This volume will contain all of the protocols and codes for patient education, what protocols changed, and the index to the protocols. You can print this volume in its entirety; by doing this Volume 1 and Volume 2 would comprise the entire Patient Education manual. However, you could print the protocols and codes by name on the IHS Web site (instead of all of Volume 2).

We have endeavored to get the Patient Education manual into a more manageable document.

Important Changes In The 14th Edition

CHEMICAL DEPENDENCY CHANGE: Reminder: The mnemonic CD for Chemical Dependency has been changed to AOD - Alcohol and Other Drugs. Questions/concerns about this change should be addressed to Gabriel.Longhi@ihs.gov, BH representative.

CULTURAL/SPIRITUAL ASPECTS Of HEALTH (CUL): CUL is to be used to document education/counseling that reflects an integration of the impact and influences that cultural and spiritual traditions, practices, and beliefs have on health and wellness.

MEDICAL NUTRITION THERAPY (MNT): MNT has been added to many of the Protocols and Codes. Only Registered Dietitians are permitted to use the MNT code. Questions concerning the MNT protocols and codes should be directed to Cecilia.butler@ihs.gov .

WELLNESS CHANGE: The mnemonic WL has been changed to HPDP - Health Promotion Disease Prevention. Questions concerning HPDP protocols and codes should be directed to Freda.carpitcher@ihs.gov

GRIEF:. In addition to Grief with losses at "end of life" GRIEF was added to address the education provided to patients who are grieving because of other losses. These losses may include a home, a spouse through divorce, a job, or even a favorite pet. The standards are general so they can be adapted to a wide variety of situations.

LITERATURE CHANGE: The title for literature given to the patient was previously Patient Education Literature. It has been changed to Literature (L).

CASE MANAGEMENT (CM): The title previously associated with the mnemonic CM was *Care* Management. The title for CM has been changed to *Case* Management.

RHEUMATIC DISEASE CHANGE: The PEP-C previously contained a topic and mnemonic called Rheumatic Disease (RD). This will be inactivated and the new topic/mnemonic is RA – Rheumatic Arthritis. We have plans to develop protocols for Ostoarthritis and Juvenile Rheumatoid Arthritis. Most other "Rheumatic Diseases" can be covered with the mnemonic ATO- Autoimmune Disorders.

HEART FAILURE CHANGE: The PEP-C previously contained a topic and mnemonic called Congestive Heart Failure (CHF). This will be inactivated and the new topic/mnemonic is HF – Heart Failure. A Discharge Literature code (HF-DCHL) was added to address the CMS requirement of discharge literature.

SUICIDAL BEHAVIOR (SB) CHANGE: was changed to SI - Suicidal Ideation/Gestures

CELIAC DISEASE: Celiac Disease (CEL) is a new code.

DEPRESSION (DEP): changed from Depression, Major to Depressive disorder

NEW 2008 PROTOCOLS:

ABNG: Abuse/neglect adult/child
ASLT: Assault
BITE: Bites, animal/human
CO: Constipation
ENCOP: Encopresis
FOOT: Foot, podiatry
FTT: Failure to thrive
LICE: Head Lice
NOSE: Epistaxis
OBSC: Obesity Childhood
PTSD: Post traumatic stress disorder
RMSF: Rocky Mountain Spotted Fever
SINUS: Sinus Infection
STING: Insect Stings
YEAST: Yeast Infection

NEW 2008 SUBTOPIC CODES:

DCHL: Discharge Literature
ISEC: Infant Security
LP: Leep
MR: Medication Reconcillation

NEW BARRIERS TO LEARNING CODES:

Cognitive impairment has been further defined as:

PEDI: Pediatric Cognitive impairment
LDIS: Learning disability
DEVD: Developmental Delay
DEMN: dementia
ESLA: An additional barrier English as a Second Language (ESLA) has also been added.

For the 14th edition, all protocols were revised to include no more than six Standards.

Please discard old PEP-C Manuals; download the new FY 2008 PEPC Manual from www.ihs.gov and assure that your local Information Technology Department /Computer Department has installed all current patches for RPMS.

Use and Documentation of Patient Education Codes

Why Use the Codes?

Hospital or clinic policies and procedures must clearly indicate that the facility will use the *IHS Patient Education Protocols and Codes (PEPC) Manual*. A copy of the entire PEPC Manual must be located within the hospital/clinic policies and procedures.

Use of the codes helps nurses, physicians, and other healthcare providers to document and track patient education. While it is desirable to spend 15, 30, even 60 minutes making an assessment of educational needs, provide the education and then document the encounter - the reality of a busy clinical practice often requires us to do this in a more abbreviated fashion. The codes allow the educator a quick method of documenting that education took place during a given patient visit. The codes are then entered into RPMS and RPMS transfers that information not only to the National Patient Information Resource System (NIPRS) but the information is also transferred to the individual patient health summary. The information located on the patient's chart informs everyone using the patient's chart that a given patient received education on specific topics. Use of the codes reflects that a minimum of education (i.e., the protocols) were provided to the patient.

The codes are limited in that they do not detail the exact nature of the education – locally developed lesson plans should reflect *exactly* what was taught – but locally developed lesson plans must be built upon the protocols contained in the Manual. Use of the protocols for patient education does not preclude the development and use of lesson plans. Good education requires that lessons plans be developed that are built upon the foundation of the protocols. The codes are merely an abbreviated tool used to document the comprehensive education that was provided. Using these codes consistently will show the pattern of education provided and encourage subsequent health professionals to do the appropriate follow-up. For instance, a typical health summary for a diabetic patient might show the following history of patient education:

07/19/05 DM-Nutrition, poor understanding, 10 min. (Provider Initials) GS: Pt. will include 5 veg/fruit/day
10/27/05 DM-Foot care, good understanding, 7 min. (Provider Initials)GM: Pt included 5 veg/fruit/day
11/07/05 DM-Exercise, good understanding, 15 min. (Provider Initials) GS: Pt. will walk 5 dys/wk/30 min.

A reasonable interpretation of this summary tells you that this patient is trying to understand management of the patient's diabetes.

Charting and the Codes

Use of the codes *does not* preclude or require writing a note on educational encounters. Whenever a health professional spends considerable time providing education in a one-on-one setting, that visit should be recorded as an independent, stand-alone visit. The primary provider can incorporate the educational information into the SOAP note and use the codes to summarize the visit and get the information onto the health summary. If the patient sees both a physician and a

nurse during the same visit and the nurse completes a lengthy educational encounter, two PCC forms should be used—one for the physician visit and one for the nursing visit. In that particular case the patient had two primary care encounters during the same day.

How to Use the Codes

The PCC forms on the following pages illustrate appropriate documentation of patient education.

Recording the Patient's Response to Education

The patient's response to education is the patient's reported level of understanding. One way of accessing the understanding is the teach-back method. (Teach-back is the patient's ability to restate what was taught.) The patient's level of understanding should be assessed in conjunction with barrier to learning, readiness to learn, and learning preferences. The following "Levels of Understanding" must be used:

Good (**G**):	Verbalizes understanding Able to return demonstration or teach-back correctly
Fair (**F**):	Verbalizes need for more education Incomplete return demonstration or teach-back indicates partial understanding
Poor (**P**)	Does not verbalize understanding Unable to return demonstration or teach-back
Refuse (**R**):	Refuses education
Group (**Gp**):	Education provided in group. Unable to evaluate individual response

Documenting Patient Education (Forms)

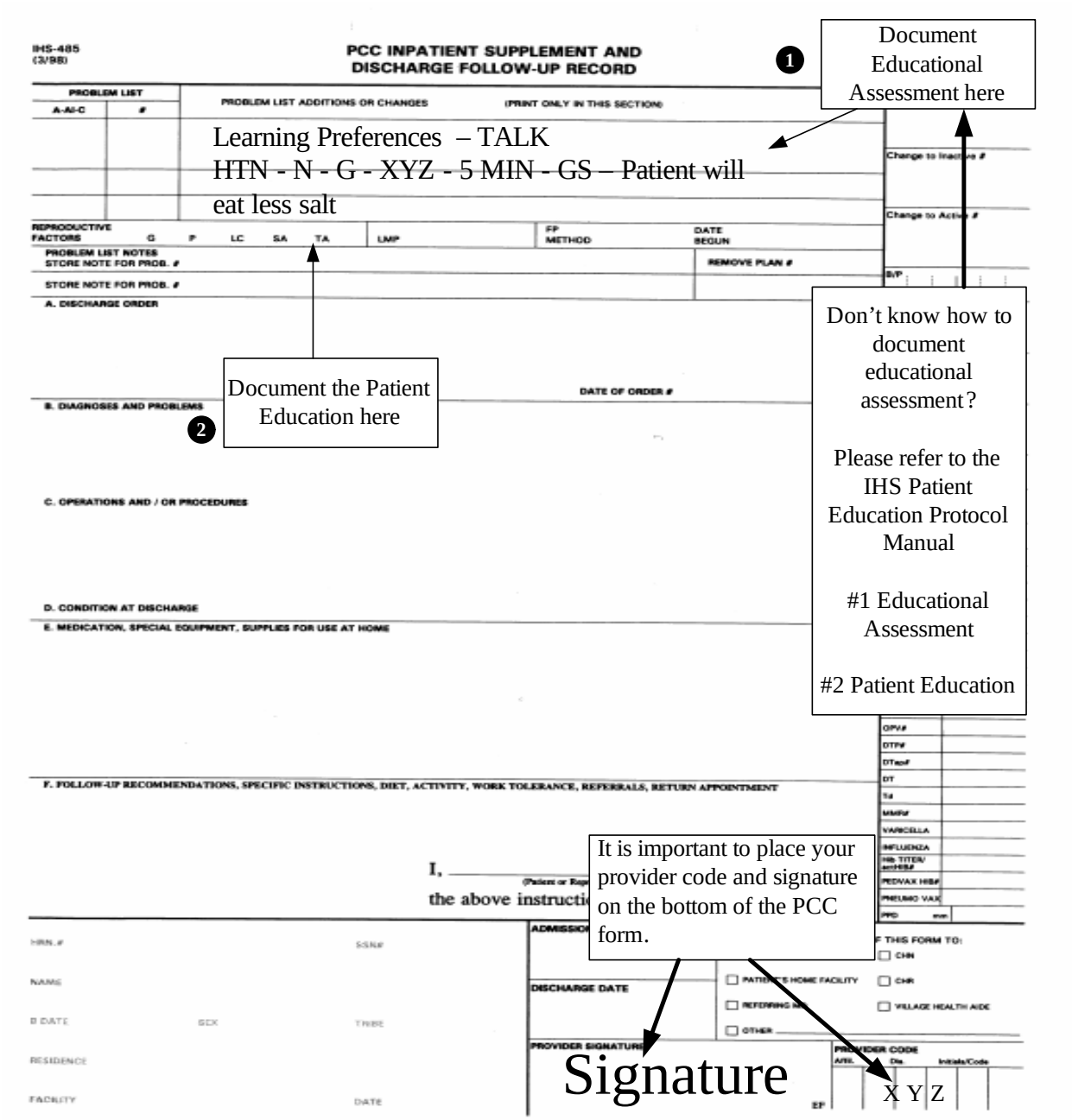


Figure 1: ***Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.***

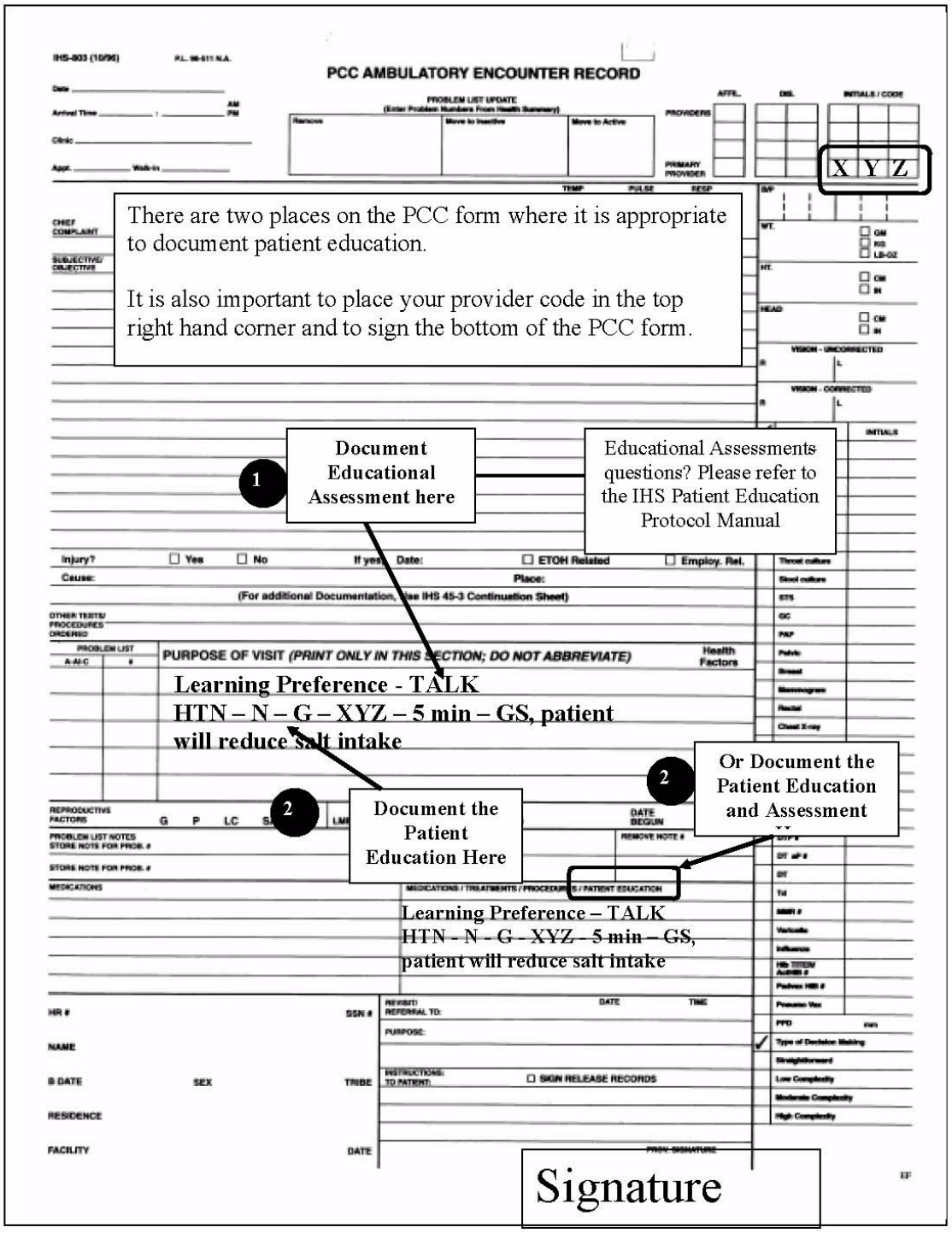
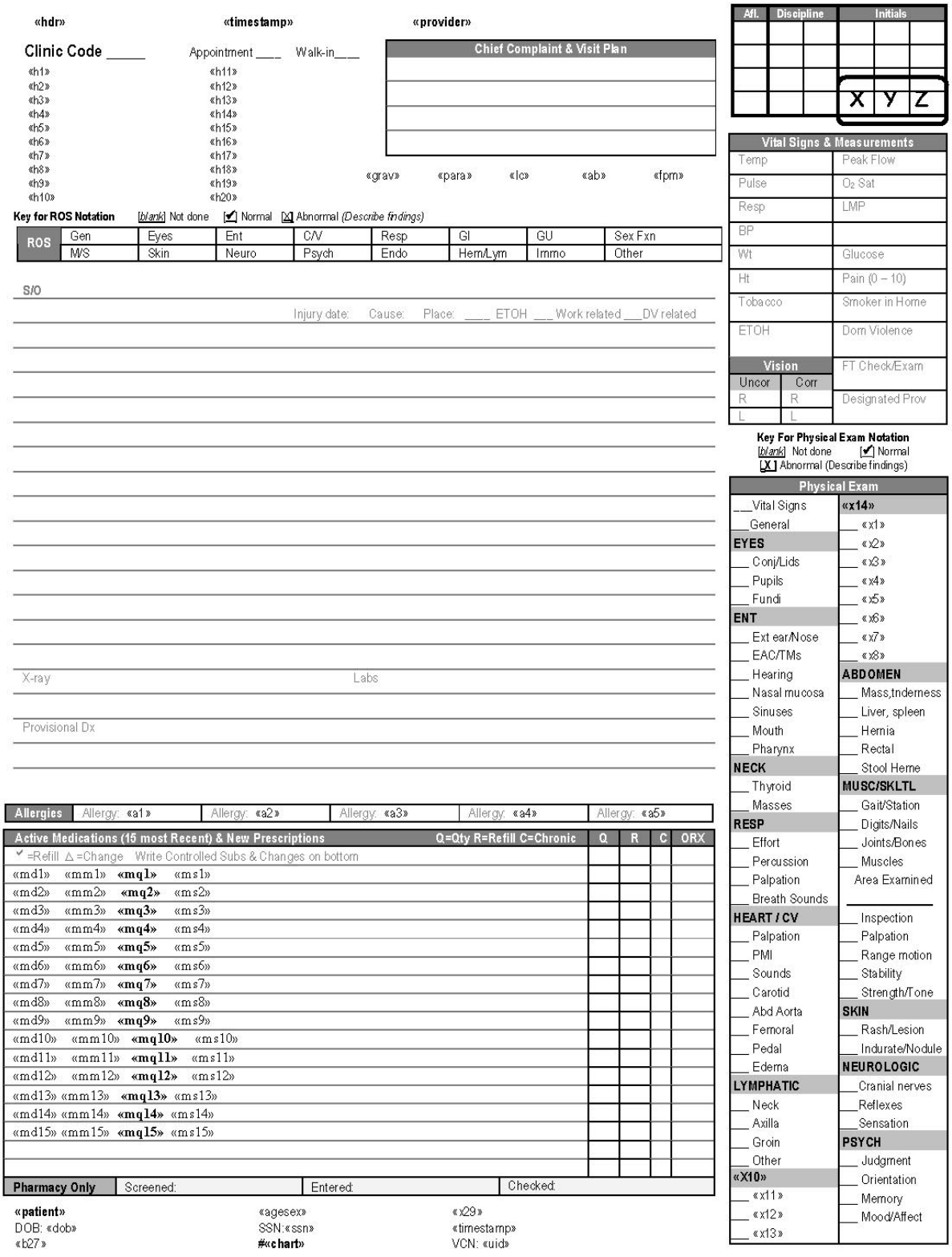


Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form

Figure 3: Documenting Patient Education on a PCC+ form, page 1



«hdr» «timestamp» «provider»

Clinic Code _____ Appointment ___ Walk-in___

«h1» «h11»
«h2» «h12»
«h3» «h13»
«h4» «h14»
«h5» «h15»
«h6» «h16»
«h7» «h17»
«h8» «h18»
«h9» «h19»
«h10» «h20»

Chief Complaint & Visit Plan

«grav» «para» «lc» «ab» «fpm»

Atl.	Discipline	Initials		
		X	Y	Z

Key for ROS Notation [blank] Not done [✓] Normal [X] Abnormal (Describe findings)

ROS	Gen	Eyes	Ent	C/V	Resp	GI	GU	Sex Fxn
	M/S	Skin	Neuro	Psych	Endo	Hem/Lym	Immo	Other

Vital Signs & Measurements	
Temp	Peak Flow
Pulse	O_2 Sat
Resp	LMP
BP	
Wt	Glucose
Ht	Pain (0 – 10)
Tobacco	Smoker in Home
ETOH	Dom Violence
Vision	FT Check/Exam
Uncor / Corr	
R / R	Designated Prov
L / L	

S/O

Injury date: Cause: Place: ____ ETOH ___ Work related ___DV related

X-ray Labs

Provisional Dx

Key For Physical Exam Notation
[blank] Not done [✓] Normal
[X] Abnormal (Describe findings)

Physical Exam	
___Vital Signs	«x14»
___General	___ «x1»
EYES	___ «x2»
___ Conj/Lids	___ «x3»
___ Pupils	___ «x4»
___ Fundi	___ «x5»
ENT	___ «x6»
___ Ext ear/Nose	___ «x7»
___ EAC/TMs	___ «x8»
___ Hearing	ABDOMEN
___ Nasal mucosa	___ Mass,tnderness
___ Sinuses	___ Liver, spleen
___ Mouth	___ Hernia
___ Pharynx	___ Rectal
NECK	___ Stool Heme
___ Thyroid	MUSC/SKLTL
___ Masses	___ Gait/Station
RESP	___ Digits/Nails
___ Effort	___ Joints/Bones
___ Percussion	___ Muscles
___ Palpation	Area Examined
___ Breath Sounds	_____
HEART / CV	___ Inspection
___ Palpation	___ Palpation
___ PMI	___ Range motion
___ Sounds	___ Stability
___ Carotid	___ Strength/Tone
___ Abd Aorta	SKIN
___ Femoral	___ Rash/Lesion
___ Pedal	___ Indurate/Nodule
___ Edema	NEUROLOGIC
LYMPHATIC	___ Cranial nerves
___ Neck	___ Reflexes
___ Axilla	___ Sensation
___ Groin	PSYCH
___ Other	___ Judgment
«X10»	___ Orientation
___ «x11»	___ Memory
___ «x12»	___ Mood/Affect
___ «x13»	

Allergies	Allergy: «a1»	Allergy: «a2»	Allergy: «a3»	Allergy: «a4»	Allergy: «a5»

Active Medications (15 most Recent) & New Prescriptions Q=Qty R=Refill C=Chronic	Q	R	C	ORX
✓=Refill △=Change Write Controlled Subs & Changes on bottom				
«md1» «mm1» **«mq1»** «ms1»				
«md2» «mm2» **«mq2»** «ms2»				
«md3» «mm3» **«mq3»** «ms3»				
«md4» «mm4» **«mq4»** «ms4»				
«md5» «mm5» **«mq5»** «ms5»				
«md6» «mm6» **«mq6»** «ms6»				
«md7» «mm7» **«mq7»** «ms7»				
«md8» «mm8» **«mq8»** «ms8»				
«md9» «mm9» **«mq9»** «ms9»				
«md10» «mm10» **«mq10»** «ms10»				
«md11» «mm11» **«mq11»** «ms11»				
«md12» «mm12» **«mq12»** «ms12»				
«md13» «mm13» **«mq13»** «ms13»				
«md14» «mm14» **«mq14»** «ms14»				
«md15» «mm15» **«mq15»** «ms15»				

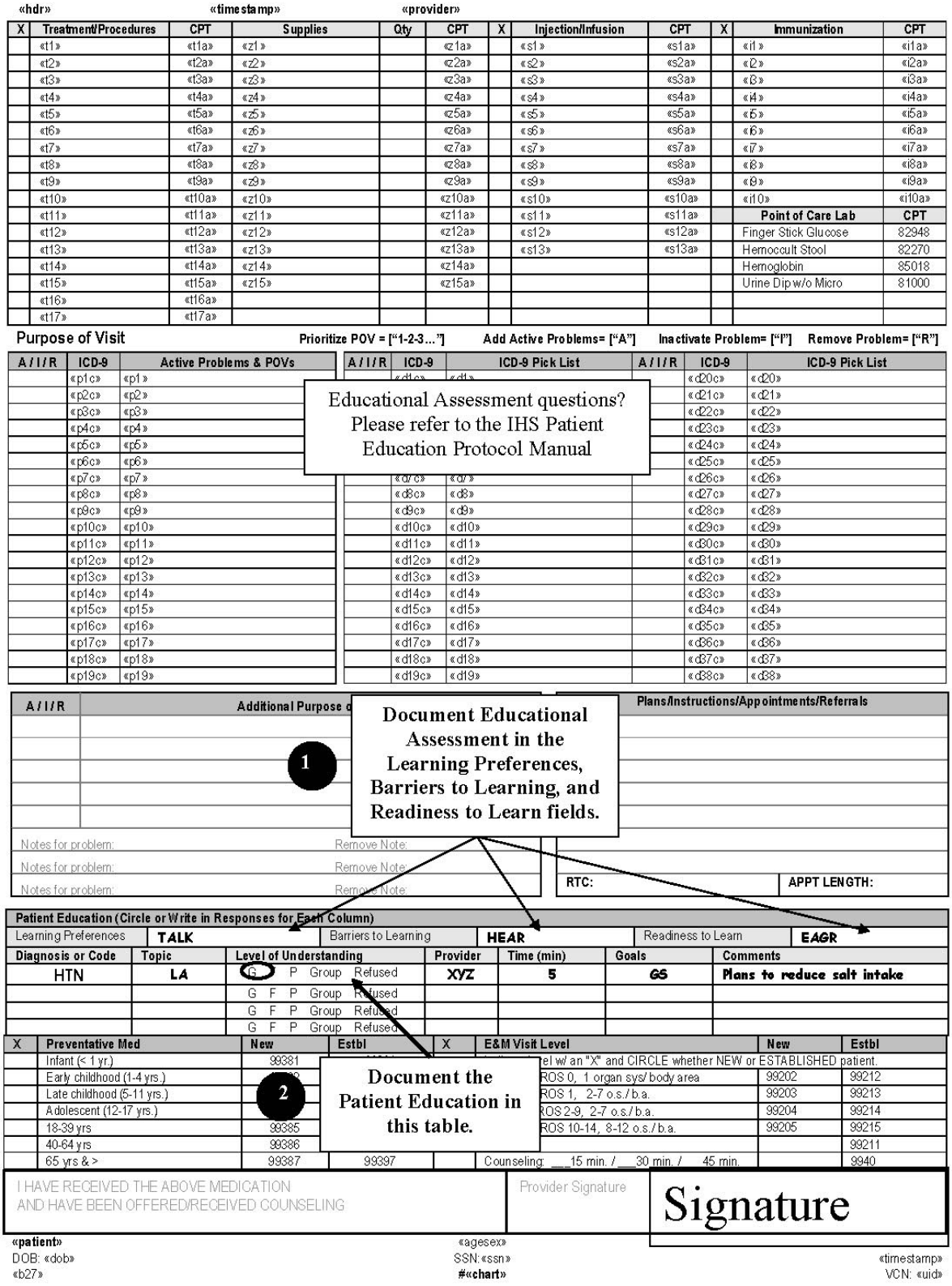
Pharmacy Only	Screened:	Entered:	Checked:

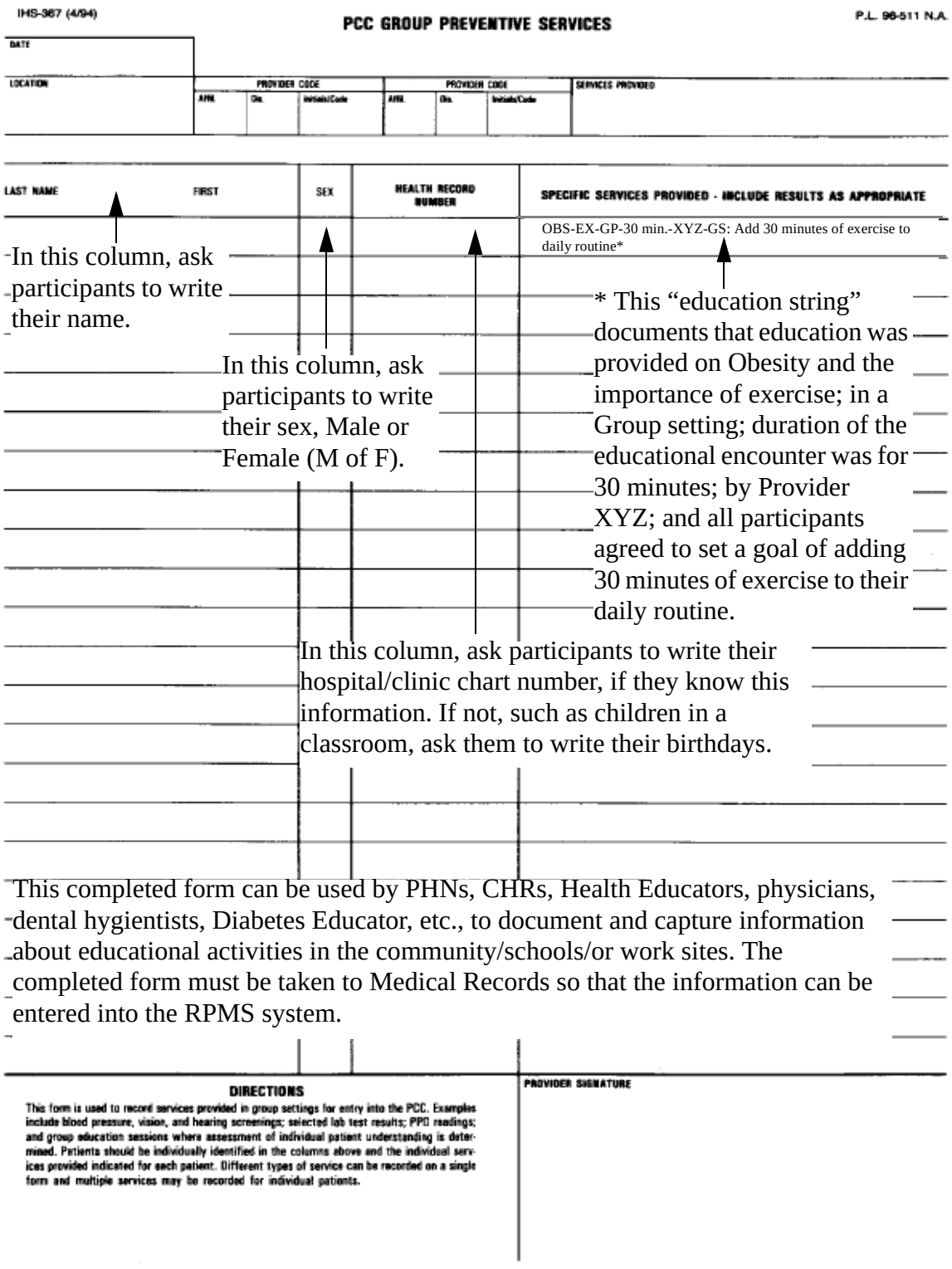
«patient»
DOB: «dob»
«b27»

«agesex»
SSN:«ssn»
#«chart»

«x29»
«timestamp»
VCN: «uid»

Figure 4: Documenting Patient Education on a PCC+ form, page 2





IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 94-511 N.A.

DATE

LOCATION

PROVIDER CODE (AFM. | Dis. | Initials/Code)

PROVIDER CODE (AFM. | Dis. | Initials/Code)

SERVICES PROVIDED

LAST NAME	FIRST	SEX	HEALTH RECORD NUMBER	SPECIFIC SERVICES PROVIDED - INCLUDE RESULTS AS APPROPRIATE
				OBS-EX-GP-30 min.-XYZ-GS: Add 30 minutes of exercise to daily routine*

In this column, ask participants to write their name.

In this column, ask participants to write their sex, Male or Female (M of F).

In this column, ask participants to write their hospital/clinic chart number, if they know this information. If not, such as children in a classroom, ask them to write their birthdays.

* This "education string" documents that education was provided on Obesity and the importance of exercise; in a Group setting; duration of the educational encounter was for 30 minutes; by Provider XYZ; and all participants agreed to set a goal of adding 30 minutes of exercise to their daily routine.

This completed form can be used by PHNs, CHRs, Health Educators, physicians, dental hygientists, Diabetes Educator, etc., to document and capture information about educational activities in the community/schools/or work sites. The completed form must be taken to Medical Records so that the information can be entered into the RPMS system.

DIRECTIONS

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure, vision, and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of service can be recorded on a single form and multiple services may be recorded for individual patients.

PROVIDER SIGNATURE

Figure 5:Form used by all healthcare workers providing education in the community, schools, work sites, etc.

Recording Goals

OBJECTIVE	DEFINITION	ACTION	MNEMONIC
Goal Set	The preparation phase defined as "patient ready to change" (patient is active)	State a plan • State a plan how to maintain at least one _____ • Write a plan of management • Plan to change _____ • State a plan to test _____(blood sugar) • Choose at least one change to follow _____ • Demonstrate ____ and state a personal plan for _____ • Identify a way to cope with _____	GS
Goal Not Set	The pre-contemplation phase defined as "patient is not thinking about change"	Goal Not Set	GNS
Goal Met	The action phase defined as "patient activity making the change" or maintenance phase defined as "patient is sustaining the behavior change"	Behavior Goal Met • Patient maintains goal	GM
Goal Not Met	The contemplation phase defined as "patient is unsure about the change" or relapse when the patient started making the change and did not succeed due to ambivalence or other	Behavior Goal Not Met • Patient set a goal but is ambivalent about change • Relapse • Patient set a goal but is unable to meet the goal	GNM

The PCC Coders can only select "Good, Fair, Poor, Group, or Refused" for the level of understanding. Remember, this section is meant for speedy documentation of brief educational encounters. If you wish to write a more lengthy narrative, please do so, on a separate PCC form using the codes to simply summarize your note. On inpatient PCCs each entry must be prefaced by a date.

INPATIENT EDUCATION FORM

READINESS TO LEARN (RL Code)	
Eager to Learn	**RL-EAGR**
Receptive	**RL-RCPT**
Unreceptive	**RL-UNRC**
Pain	**RL-PAIN**
Severity of Illness	**RL-SVIL**
Distraction	**RL-DSTR**
Assessed each teaching session	

PATIENT'S RESPONSE TO EDUCATION (Level of Understanding Code)

- G - GOOD - *Verbalized understanding. Able to return demonstration or teach back correctly.*
- F - FAIR - *Verbalizes need for more education. Incomplete return demonstration or teach back indicates partial understanding.*
- P - POOR - *Does not verbalize understanding. Unable to return demonstration or teach back.*
- R - REFUSED - *Refuses education.*
- GP - GROUP - *Education provided in group. Unable to evaluate individual response.*

LEARNING PREFERNCE (LP) - assessed annually				
Do/Practice ® **LP –DOIT**	Group ® **LP –GP**	Read ® **LP –READ**	Talk (one on one) ® **LP –TALK**	Media ® **LP –MEDIA**

BARRIERS TO LEARNING (BAR) *(Check those that apply)*					
☐ No Barrier BAR-NONE	☐ Doesn't Read English BAR-DNRE	☐ Hard of Hearing BAR-HEAR	☐ Deaf BAR-DEAF	☐ Learning Disability BAR-LDISN	☐ Values/Beliefs BAR-VALU
☐ Emotional Stressors BAR-EMOT	☐ Interpreter Needed BAR-INTN	☐ Visually Impaired BAR-VISI	☐ Educ <6 grade BAR-EDUC	☐ Developmental Delay BAR-DEVD	☐ Fine Motor Skills BAR-FIMS
☐ Social Stressors BAR-STRS	☐ English 2nd Language BAR-ESLA	☐ Blind BAR-BLND	☐ Pediatric BAR-PEDI	☐ Dementia BAR-DEMN	

List measures taken to address barriers or other comments: _____

Date/ Time	Readiness to Learn	Patient Education Code	Understanding	Person Taught	Provider Signature/Code	Time (min)	Goal Set, Met, Not Set, Not Met
		ADM-POC Plan of Care	G F P R Gp	☐ Patient ☐ Other			
		ADM-OR Orientation	G F P R Gp	☐ Patient ☐ Other			
		ADV–S Safety	G F P R Gp	☐ Patient ☐ Other			
		ADV-I Advance Directive, Info	G F P R Gp	☐ Patient ☐ Other			
		_____-N fill in code for nutrition education	G F P R Gp	☐ Patient ☐ Other			
		_____-EX fill in code for physical activity education	G F P R Gp	☐ Patient ☐ Other			

Date	CRS Screening	Result	Pt Education if "positive" screen	Time	Provider
	Int. Partner/Dom. Violence Exam Code #34	☐ Negative ☐ Present ☐ Past ☐ Refused ☐Unable	☐ N/A RL: Person: DV-_____ Understanding: Goal Set? ____what?_____		
	Alcohol Exam Code #35 -or- Health Factor	☐ Normal/Negative ☐ Abnormal/Positive ☐ Refused CAGE ____/4 (health factor only)	☐ N/A RL: Person: AOD-_____ Understanding: Goal Set? ____what?_____		
	Depression Exam Code #36	☐ Normal/Negative ☐ Abnormal/Positive ☐ Refused	☐ N/A RL: Person: DEP-_____ Understanding: Goal Set? ____what		
	Tobacco Health Factor	☐ Non Tobacco User ☐ Smoke Free Home Circle all qualifiers for tobacco use: Cessation: Smoker/Smokeless Current: Smoker/Smokeless Previous: Smoker/Smokeless (<6mo) Exposure to Environ. Smoker in home	☐ N/A RL: Person: TO-_____ Understanding: Goal Set? ____what?_____		

«patient»		Chart # «chart»	«timestamp»
DOB: «dob»	«agesex»	PCP: «b14»	VCN: «uid»
«b27»			

INPATIENT EDUCATION FORM

Figure 1: Documenting Inpatient Education Record, Part 1

Commonly Used Illness or Condition Codes And specific subtopics related to those codes		**Commonly Used Education Topics**
ASM - Asthma	HTN - Hypertension	AP - Anatomy and Physiology
PL - Pulmonary	IM - Immunization	C - Complications
ASM/PL - MDI meter dose inhaler	IM - DEF deficiency	DP - Disease Process
ASM/PL - NEB nebulizer	IM - SCH schedule	EQ - Equipment
ASM/PL - PF peak flow	INJ - Injuries	EX - Exercise
ASM/PL - SPA spacer	INJ - CC cast care	FU - Follow Up
BL - Blood Transfusion	INJ - WC wound care	HM - Home Management
CP - Chest Pain	MEDS - Medical Safety	HY - Hygiene
HF - Heart Failure	PM - Pain Management	L - Literature
CKD - Chronic Kidney Disease	PT - Physical Therapy	LA - Lifestyle Adaptations
CPM - Chronic Pain Management	PT - GT gait training	M - Medications
DM - Diabetes	PT - WC wound care	MNT - (dietitian use only)
DV - Domestic Violence	PNM - Pneumonia	N - Nutrition
LIP - Dyslipidemia	PNM/PL - IS incent spirom	P - Prevention
EOL - End of Life	RST - Restraints	PRO - Procedure
EOL - GP grieving process	SWI - Skin & Wound Infections	S - Safety
EOL - ADV advance directive	SWI - WC wound care	SHS - Second Hand Smoke
F - Fever	TO - Tobacco Use	TE - Tests
GER - GERD	URI - Upper Respiratory Infection	TO - Tobacco
		TX - Treatment

Date/ Time	Readiness to Learn (RL)	Education Code with subtopic	Understanding Code	Person Taught	Provider Signature/Code	Time (min)	Goal Set, Met, Not Set, Not Met (state specific goal
			G F P R Gp	☐ Patient ☐ Other			
			G F P R Gp	☐ Patient ☐ Other			
			G F P R Gp	☐ Patient ☐ Other			
			G F P R Gp	☐ Patient ☐ Other			
			G F P R Gp	☐ Patient ☐ Other			
			G F P R Gp	☐ Patient ☐ Other			
			G F P R Gp	☐ Patient ☐ Other			
		DCH-M Discharge Med Education	G F P R Gp	☐ Patient ☐ Other			
		HF-DCHL Required literature for all pts with HF	G F P R Gp	☐ Patient ☐ Other			
		DCH-POC Discharge Plan of Care	G F P R Gp	☐ Patient ☐ Other			
		DCH-FU Discharge Follow-u	G F P R Gp	☐ Patient ☐ Other			

«patient»		Chart # «chart»	«timestamp»
DOB: «dob»	«agesex»	PCP: «b14»	VCN: «uid»
«b27»			

Figure 2: Documenting Inpatient Education Record, Part 2

PSYCHOSOCIAL

You have the right to refuse to answer any of these questions

Depression Screen (Exam Code 36 Depression Screening Wellness tab)

Screening for pt ≤ 14 y/o: N/A □

Do you cry a lot? No Yes □

Do you cry for no apparent reason? No □ Yes □

Do you feel lonely even when other people are around No Yes **Refused:_____**

"Yes" to any question above OR if depression suspected in parent/caregiver & interfering with child's care, further evaluation indicated

In the last two weeks, how often have you been bothered by:

Little interest or pleasure in doing things?

__ (0) Not at all __(1) Several days __(2) More than half the days __(3) Nearly every day

Feeling down, depressed or hopeless: TOTAL SCORE_____

__ (0) Not at all __(1) Several days __(2) More than half the days __(3) Nearly every day

Normal/Negative ≤2 Abnormal ≥3 need further evaluation (using PHQ-9 or other diagnostic tool)

Tobacco (Health Factor Tobacco Wellness tab)

Do you (patient) currently use any Tobacco Products? (age 5yo) N/A □ **Refused:_____**

Any tobacco (cigarette/chewing) use in the last year? No □ Yes □ (Type_____ Amount_____How long_____)

No □ Non-Tobacco user

Yes □ Current smokerCurrent smokeless Current Smoker and Smokeless Ceremonial Use

Type_____ Amount_____ How long_____

If yes, educate about cessation options & document education

Have you ever used any Tobacco Products?

No □ Non-user

Yes □ Previous Smoker Previous Smokeless (Previous – no tobacco use for > 6 months)

Cessation Smoker Cessation Smokeless (Cessation – no tobacco use for < 6 months)

Any Exposure to Tobacco Smoke?

No Smoke free home

Yes Smoker in Home, Exposure to environmental Smoke (outside of home)

Alcohol/Drugs (Health Factor Alcohol/Drugs or Exam Code 35 Wellness tab)

Pt ≤ y/o: Do you (patient) or anyone in house use alcohol or drugs? No Self Other □ Comments _____

If yes for self, further evaluation indicated, document as exam code 35 – abnormal/positive **Refused _____**

If no for self, document as exam code 35 – normal/negative

If suspected in parent/caregiver & interfering with child's care, further evaluation indicated.

Do you use? Alcohol Marijuana Cocaine Meth Other Drugs How Often_____ How Long_____ NonUser____

Was last drink within the past 72 hours No Yes (If yes, consider CIWA)

Pt ≥ 21 y/o that has answered yes to alcohol - administer CAGE questionnaire:

C – Have you ever felt you should CUT down on your drinking? No Yes □

A – Have people ANNOYED you by criticizing your drinking?No Yes □

G – Have you ever felt bad or GUILTY about your drinking?No Yes CAGE Score____

E – Have you ever had a drink (or used drugs) first thing in the morning to steady your nerves, get rid of hangover or get the day started (EYEOPENER)? No □ Yes □

total yes 0/4 1/4 2/4 3/4 4/4

*if at least one yes further evaluation indicated

IPV/DV-Intimate Partner /Domestic Violence (Exam 34 Intimate Partner Violence, Wellness tab)

Ask of patient when no family/visitors are present. Peds, ask of parent/caregiver to determine if existence for patient.**Refused** _____

Do you feel safe with the people you live with or spend time with? No Yes Past □ **Unable** _____

Are you afraid to go home? No Yes Past □

Has anyone forced you to have sexual activities recently? No Yes Past □ Want Help: Yes No

General Education Subtopics

(using EDC-9 diagnosis instead of PEPC to document education)

Guidelines For Use

The following subtopic can be used in conjunction with any ECD-9 diagnosis to document patient/family education. The general subtopics should not be used with standard patient education codes. Standard codes can be found in the IHS Patient Education Protocols and Codes Manual (PEPC). As with PEPC, covering 50% of the standards under a subtopic justifies use of the education coding system. The list below is NOT exhaustive, nor is it intended to be.
The provider will write out the following: 1) ICD-9 code or diagnosis, 2) education subtopic, 3) level of understanding (G, F, P, R, Gp), 4) Provider Code or Initials, 5) Time spent providing the education, and 6) GS for Goal set, GM for Goal Met, and GNM for Goal Not Met if the patient set a goal; use GNS for Goal Not Set if the patient did not set a goal. For example:

(132.9) Pediculosis – TX – F <provider initials> 10min. – GS: Pt. will wash linens

This would show up on the health summary under the patient education section as:

(132.9) Pediculosis – treatment – fair understanding, 10 minutes, Goal Set: Pt. will wash linens

The General Education Subtopics used with ICD-9 diagnoses are:

AP - Anatomy & Physiology
C - Complications
DP - Disease Process
EQ - Equipment
EX - Exercise
FU - Follow-up
HM - Home Management
HY - Hygiene
L - Literature
LA - Lifestyle Adaptations
M - Medications
MNT - Medical Nutrition Therapy (Reg. Dietitian use only)
N - Nutrition
P - Prevention
PRO - Procedures
S - Safety
TE - Tests
TX - Treatment

General Education Subtopics Listing

AP - ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain normal anatomy and physiology of the systems involved.
2. Discuss the changes to anatomy and physiology as a result of this disease process or condition, as appropriate.
3. Discuss the impact of these changes on the patient's health or well being.

C - COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences as a result of this disease state/condition, the failure to manage this disease state/condition, or those that are a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the disease state/ condition.
2. Describe the signs/symptoms of common complications of this disease state/ condition.

DP - DISEASE PROCESS

OUTCOME: The patient/family will understand the condition/disease.

STANDARDS:

1. Discuss the current information regarding causative factors and pathophysiology of the disease state/condition.
2. Discuss the signs/symptoms and usual progression of the disease state/condition.
3. Discuss the signs/symptoms of exacerbation/worsening of the disease state/ condition.

EQ - EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) the proper use and care of home medical equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
    a. Indication for the equipment
    b. Benefits of using the equipment
    c. Types and features of the equipment
    d. Proper function of the equipment
    e. Signs of equipment malfunction and proper action in case of malfunction
    f. Infection control principles, including proper disposal of associated medical supplies
    g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.

EX - EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in the patient's disease process or condition.

STANDARDS:

1. Discuss the medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

FU - FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of the patient's disease or condition.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.

3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss the signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

HM - HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the disease process/condition.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

HY - HYGIENE

OUTCOME: The patient/family will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Discuss the importance of hand-washing in infection control, especially in relationship to food preparation/consumption, child care, and toilet use.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

L - LITERATURE

OUTCOME: The patient/family will receive literature about the disease process or condition.

STANDARDS:

1. Provide the patient/family with literature on the disease state or condition.
2. Discuss the content of the literature.

LA - LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to prevent complications of the disease state/condition or to improve mental or physical health.

STANDARDS:

1. Review the lifestyle aspects/changes that the patient has control over: nutrition, physical activity, safety and injury prevention, avoidance of high risk behaviors, and full participation in the treatment plan.
2. Emphasize that an important component in the prevention or treatment of the disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

M - MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

MNT - MEDICAL NUTRITION THERAPY

(* FOR USE BY REGISTERED DIETITIANS ONLY ***)**

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed in the disease state/condition.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

N - NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to the patient's disease or condition.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
4. Refer to registered dietitian for MNT or other local resources as appropriate.

P - PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing diseases, condition, or complications.

STANDARDS:

1. Discuss lifestyle behaviors that increase the risk for the onset, progression, or spread of a specific disease/condition.
2. Discuss the behaviors that reduce the risk for the onset, progression, or spread of a specific disease/condition.

PRO - PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including the indications, complications, and alternatives, as well as, possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedure as well as the alternatives and the risk of non-treatment.
2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Discuss pain management as appropriate.

S - SAFETY

OUTCOME: The patient/family will understand safety as it relates to the patient's disease or condition.

STANDARDS:

1. Explain that injuries are a major cause of death/disability.
2. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition (home safety, car safety, work safety, recreation safety).

TE - TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
    a. method of testing
    b. necessity, benefits, and risks of test(s) to be performed
    c. any potential risk of refusal of recommended test(s)
    d. any advance preparation and instructions required for the test(s)
    e. how the results will be used for future medical decision-making
    f. how to obtain the results of the test
2. Explain test results:
    a. meaning of the test results
    b. follow-up tests may be ordered based on the results

c. how results will impact or effect the treatment plan

d. recommendations based on the test results

TX - TREATMENT

OUTCOME: The patient/family will understand the treatment plan.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

MNT - Medical Nutrition Therapy

****For Use By Registered Dietitians Only****

Medical Nutrition Therapy (MNT) is the use of specific nutrition interventions based on standardized guidelines that incorporate current professional knowledge and research to treat an illness, injury, or condition. Nutrition interventions are determined on an assessment that includes a review and analysis of medical and diet history, biochemical and anthropocentric measures. MNT plays a key role through out the life cycle of an individual and integrates in the continuum of care in all levels of practice.

The Dietetic Practitioner, also referred to as a Registered Dietitian (RD), is the professional uniquely qualified to provide MNT.

Registered Dietitian: An individual who has completed the minimum of a baccalaureate degree granted by a U.S. regionally accredited college or university or foreign equivalent, has met current minimum academic requirements and completed a pre-professional experience, and has successfully completed the Registration Examination for Dietitians. All RDs must accrued 75 hours of approved continuing professional education every 5 years to maintain Registration through the Commission on Dietetic Registration.

Education Needs Assessment Codes

INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES

LP - Learning Preference	**Mnemonics**
1. Talk	LP-TALK
2. Media	LP-MEDIA
3. Group	LP-GP
4. Read	LP-READ
5. Do/Practice	LP-DOIT

RL - Readiness to Learn

1. Eager	RL-EAGR
2. Receptive	RL-RCPT
3. Unreceptive	RL-UNRC
4. Pain	RL-PAIN
5. Severity of Illness	RL-SVIL
6. Distraction	RL-DSTR

BAR - Barriers to Learning

1. No Barriers	BAR-NONE
2. Does Not Read English	BAR-DNRE
3. Interpreter Needed	BAR-INTN
4. English as a Second Language	BAR-ESLA
5. Dementia	BAR-DEMN
6. Learning Disability	BAR-LDIS
7. Developmental Delay	BAR-DEVD
8. Fine Motor Skills Deficit	BAR-FIMS
9. Hard of Hearing	BAR-HEAR
10. Deaf	BAR-DEAF
11. Visually Impaired	BAR-VISI
12. Blind	BAR-BLND
13. Social Stressors	BAR-STRS
14. Emotional	BAR-EMOT
15. Values/Belief	BAR-VALU
16. Childhood Developmental	BAR-PEDI

BAR - Barriers to Learning

Barriers to learning are PATIENT specific and documented as a Health Factor in the medical record. They usually are not visit specific, but rather relate to the patient's overall health status. Barriers are assessed by observation and interview, and then documented to alert other healthcare providers that may provide education. It is important to accommodate and overcome barriers in order to enhance patient learning. Examples of how to overcome barriers to learning may include:

- Involve a family member or care taker in the education
- Minimize education to "need to know" information
- Speak loudly and clearly
- Communicate in writing
- Provide written materials that are low-literacy and have demonstrative pictures
- Refer to mental health, social services, or community resources as appropriate
- Assist the patient in identifying adaptive technique or equipment that could accommodate the impairment.
- Utilize a translator or sign interpreter
- Use different size medication bottles or a medication box
- Use medical assisted devices
- Ask the patient: "Do you feel ready for this education session or is there too much going on right now? When would be a better time for you?"

BAR-BLND BLIND

DEFINITION: The patient is blind and can not compensate with low-vision devices.

ASSESSMENT: The patient may divert the eyes, wear sunglasses inside, state an inability to see or is diagnosed with blindness (best corrected vision is ≤ 20/200 **or** ≤20 degrees of visual field in the better eye).

BAR-DEAF DEAF

DEFINITION: The patient is deaf and can NOT compensate with increased volume or hearing devices.

ASSESSMENT: The patient may not respond to questions, may be looking intently at your lips as you speak, may motion to communicate by writing, use sign language to indicate deafness, or may have a diagnosis of deafness.

BAR-DNRE DOES NOT READ ENGLISH

DEFINITION: The patient is unable to read English.

ASSESSMENT: Ask the patient/family about the ability to read English. Patients may be embarrassed admitting they cannot read English or may make excuses such as "I forgot my glasses." This is a sensitive subject and must be treated accordingly. Stress "English"

in this evaluation and acknowledge that the patient's primary language may be unwritten. Another technique is to have the patient read a sentence that could be interpreted in different ways and ask them how they interpret the sentence. If the patient is unable, state that reading English can be hard for people that learned another language first and ask if this is applicable.

BAR-EMOT EMOTIONAL STRESSORS

DEFINITION: The patient's ability to learn is limited due to emotional stressors.

ASSESSMENT: The patient may appear distraught, avoid eye contact, or show anger. The emotional stressors may be acute or ongoing. e.g., personal issues (martial/ relationship problems, unemployment/financial stress, lack of housing, problems with children/family members) or behavioral issues (mood, anxiety, grief). Emotional stressors are internal while social stressors are external.

BAR-FIMS FINE MOTOR SKILLS DEFICIT

DEFINITION: The patient has fine motor skills impairment that can interfere with tasks requiring manual dexterity.

ASSESSMENT: The patient may have difficulty or lack the physical control to direct/ manage body movement, e.g., paralysis, arthritis, amputation, unable to handle testing supplies (for example, checking blood sugars or measuring medications).

BAR-HEAR HARD OF HEARING

DEFINITION: The patient has a problem hearing that can be compensated with increased volume or hearing devices.

ASSESSMENT: The patient may not respond to questions initially and may ask for things to be repeated, may speak loudly, may end ear/lean toward the speaker, or wears a hearing device.

BAR-INTN INTERPRETER NEEDED

DEFINITION: The patient does not readily understand spoken English.

ASSESSMENT: The patient may verbalize the need for an interpreter, answer questions inappropriately, or answer or nod "yes" to all questions. These actions could also imply hearing difficulty and may require further assessment.

BAR-NONE NO BARRIERS

DEFINITION: The patient has no apparent barriers to learning.

BAR-PEDI PEDIATRIC/DEVELOPMENTAL

DEFINITION: That patient has normal cognitive development but is too young to understand health information. There is no cut off age for this because childhood cognition can develop at different rates.

ASSESSMENT: The pediatric patient is of an age/cognition level that relies on others for care.

BAR-STRS SOCIAL STRESSORS

DEFINITION: The patient's ability to learn is limited due to social stressors from current personal difficulties or on-going mental/behavioral health issues

ASSESSMENT: The patient may appear distraught, avoid eye contact, or show anger. The stressors may be acute or ongoing. e.g., family separation and conflict, mental disorders, disease, death, alcohol/substance abuse, domestic violence. Social stressors are external while emotional stressors are internal.

BAR-VALU VALUES/BELIEF

DEFINITION: The patient has values or beliefs that may impact learning; this may also include traditional Native American/Alaska Native values/beliefs that might impact the medical/clinical aspects of healthcare.

ASSESSMENT: The patient may comment or be asked about values/beliefs in relation to health information or medical/clinical aspects of healthcare.

BAR-VISI VISUALLY IMPAIRED

DEFINITION: The patient has difficulty seeing even with best corrected vision. The difficulty can be compensated with the use of other measures/devices to improve vision (large print, better lighting, magnifying glasses).

ASSESSMENT: The patient may divert the eyes, squint, or state having difficulty seeing.

LP - Learning Preference

Learning Preference is listed in the medical record as a Health Factor. Although a patient may have a predominant way of learning, it is important to use a variety of teaching methods to optimize an education encounter. Learning preference can be evaluated when the provider deems it necessary.

The procedure for Evaluating Learning Preference is as follows:

1. Review the most common styles of adult learning (talking & asking questions, group discussion, videos, reading)
2. Explain that every individual is unique and will have their own preference(s) in how they receive new information.
3. Ask the patient/family, "How do you learn best?"

LP-DOIT DO

DEFINITION: The patient/family states that doing and participating a new skill is the preferred style of learning new information.

LP-GP GROUP

DEFINITION: The patient/family states that participating in small groups is the preferred style of learning. A group is more than one person.

LP-READ READ

DEFINITION: The patient/family states that reading is the preferred style of learning.

LP-MEDIA MEDIA

DEFINITION: The patient/family states that media (kiosk, videos, interactive displays, demonstrations, or pictorial teaching) is the preferred style of learning.

LP-TALK TALK

DEFINITION: The patient/family states that talking and asking questions is the preferred style of learning.

RL - Readiness to Learn

Readiness to Learn can be assessed through both observation and interview. Readiness to Learn is sub-topic specific while Barriers apply to the overall health status of the patient. With few exceptions (emotional, social and cognitive), Barriers to Learning tend to be more physical and slower to change.

Because of current system constraints, Readiness to Learn is documented via the Health Factors. In the future, this may be moved to be a data element under specific education subtopics.

RL-DSTR DISTRACTION

DEFINITION: The patient/family has limited readiness to learn because of distractions that cannot be minimized.

RL-EAGR EAGER

DEFINITION: The patient/family is exceedingly interested in receiving education.

RL-INTX INTOXICATION

DEFINITION: The patient/family has decreased cognition due to intoxication with drugs or alcohol.

RL-RCPT RECEPTIVE

DEFINITION: The patient/family is ready or willing to receive education.

RL-PAIN PAIN

DEFINITION: The patient/family has a level of pain that limits readiness to learn.

RL-SVIL SEVERITY OF ILLNESS

DEFINITION: The patient/family has a severity of illness that limits readiness to learn.

RL-UNRC UNRECEPTIVE

DEFINITION: The patient/family is NOT ready or willing to receive education.